



## BANK ACCOUNT CHANGE FORM

Employer Name:  Check one:  I am an employer changing banking information for my premium incentive payment.  I am an employee changing banking information for my premium assistance payment.  Bank Account Information Information collected will be used for Electronic Funds Transfer (EFT) to deposit your monthly premium incentive or premium assistance subsidy payment. Include a voided check with this form. If a voided check is not available, attach a letter from your financial institution indicating the bank transit routing and account numbers. The document must be on bank letterhead and signed by a bank official. Do not send deposit slips.  Name on Account:  Transit Routing Number (9 digits):  Bank Account Number (include zeros, do not include check number):  Type of Account (select only one):  Checking Savings Date Bank Account Opened:  Financial Institution Name:  Bank Address:  City:  State:  Zip:  Bank Phone Number:  Ext:  I certify, under penalty of law, that all my answers are correct and complete to the best of my knowledge. I understand the penalty for withholding or giving false information which may include a possible criminal offrease (MCA 33-22-2009). I agree to provide documents to verify information on this application if requested. I understand that State staff may obtain documents and/or information to verify statements on this application. I also understand that I must report if my coverage ends within 30 days of the change. Any premium assistance payment I receive and am not entitled to will be required to be repaid to the Insure Montana program.  Signature:  Date:	All changes to bank information will be	effective on the next scheduled payment.
□ I am an employer changing banking information for my premium incentive payment.  □ I am an employee changing banking information for my premium assistance payment.  ■ I am an employee changing banking information for my premium assistance payment.  ■ I am an employee changing banking information for my premium assistance payment.  ■ Information collected will be used for Electronic Funds Transfer (EFT) to deposit your monthly premium incentive or premium assistance subsidy payment. Include a voided cheek with this form. If a voided cheek is not available, attach a letter from your financial institution indicating the bank transit routing and account numbers. The document must be on bank letterhead and signed by a bank official. Do not send deposit slips.  Name on Account:  □ Transit Routing Number (9 digits):  □ Bank Account Number (include zeros, do not include check number): □ Type of Account (select only one): □ Checking □ Savings Date Bank Account Opened: □ / / □ Financial Institution Name: □ Bank Address: □ City: □ State: □ Zip: □ Ext: □ Ext: □ Lecrify, under penalty of law, that all my answers are correct and complete to the best of my knowledge. I understand the penalty for withholding or giving false information which may include a possible criminal offense (MCA 33-22-2009). I agree to provide documents to verify information on this application if requested. I understand that I must report if my coverage ends within 30 days of the change. Any premium assistance payment I receive and am not entitled to will be required to be repaid to the Insure Montana program.	Employer Name:	
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Bank Account Number (include zeros, do not include check number):  Type of Account (select only one):Checking Savings	Name on Account:	
Type of Account (select only one):CheckingSavings	Transit Routing Number (9 digits):	
Financial Institution Name:	Bank Account Number (include zeros, do not include check	number):
Bank Address:  City: State: Zip:  Bank Phone Number: Ext:  Attach voided check in this space.  Attach voided check in this space.  I certify, under penalty of law, that all my answers are correct and complete to the best of my knowledge. I understand the penalty for withholding or giving false information which may include a possible criminal offense (MCA 33-22-2009). I agree to provide documents to verify information on this application if requested. I understand that State staff may obtain documents and/or information to verify statements on this application. I also understand that I must report if my coverage ends within 30 days of the change. Any premium assistance payment I receive and am not entitled to will be required to be repaid to the Insure Montana program.	Type of Account (select only <b>one</b> ): Checking Saving	s Date Bank Account Opened://
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